October 2010

# Clinical recommendations following consultation: What the changes would mean for residents in Barking and Dagenham

## Introduction

This report is divided into two parts:

- An executive summary showing how the changes would affect residents in Barking and Dagenham.
- A longer report describing the changes across the whole of north east London.

Executive summaries for each of the north east London boroughs, south west Essex and west Essex are available on the website www.healthfornel.nhs.uk or on request (see below).

The report:

- sets out the original proposals for changing acute hospital services in north east London and how they have changed since consultation;
- explains how we think these changes would deliver improvements to local health services and address the issues of concern raised in the consultation; and
- describes what the next steps are before final decision making (scheduled for mid-December).

All the reports referred to in this document can be found at www.healthfornel.nhs.uk or on request from:

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# Executive summary for Barking and Dagenham

## Urgent care, A&E and inpatient care

All the hospitals in north east London face a range of pressing quality and sustainability issues in their current configuration. These pressures are only going to increase in the future. Hospitals are not meeting best practice for maternity and paediatrics because staff and resources are spread too thinly. The A&Es find it difficult to provide the best service to those requiring specialist care as well as dealing with more minor conditions.

The Health for north east London proposals aim to address these problems and reduce the burden on hospital services and staff. Local clinicians have endorsed the recommendation that we reduce the number of hospitals in north east London providing urgent, A&E and inpatient care from six to five – but recommended we strengthen urgent care services on all sites so that A&E services are really focused on those patients with the most serious conditions.

King George Hospital would provide 24/7 urgent care with access to a range of specifically targeted tests (e.g. ECG, x-ray, colonoscopy, blood tests); GP services and out-of-hours GPs; and a short stay assessment unit which would be open 24/7 so that we can provide a really good local alternative to A&E and inpatient care. This unit would be staffed by a team of skilled clinicians with expertise in primary care assessment and treatment as well as in emergency medicine and would carry out the initial assessment of patients arriving at King George. The service would also offer facilities for longer periods of observation, assessment and treatment including access to a range of tests not currently available to primary care clinicians, and specialist advice from hospital clinicians (including for example paediatricians, geriatricians, and mental health specialists). Staff would work closely with community health and social care services, including mental health services, so that as many patients as possible can be cared for in the community without recourse to a hospital admission.

Barking and Dagenham residents requiring full A&E or inpatient admission would need to go to nearby hospitals such as Queen's or Newham. Local A&E and hospital-based urgent care services currently see more than 80,000 Barking and Dagenham residents per year (see table below). Under the proposals we believe that the majority of Barking and Dagenham residents who currently attend King George would continue to have their urgent care needs met at King George (where at the moment more than 75% of emergency patients are discharged home without needing admission). If in future a GP or ambulance crew think it is likely a patient would require admission they would arrange for patients to be taken straight to the nearest A&E, usually Newham or Queen's hospitals.

Barking Community Hospital (due to open 2011) will provide urgent care and a walk-in service; child, outpatients, sexual health and mental health services, and a community pharmacy.

The Royal London would provide specialist care for major trauma patients, people suffering a heart attack (The London Chest) and children needing specialist care – particularly those under three.

The following table shows the current and expected demand for A&E and urgent care of **Barking and Dagenham** residents. *See also section 2 of main report.*

| **Hospital site** → / **Configuration** ↓ | King George Hospital | Queen's Hospital | Barts & the London Hospitals | Homerton Hospitals | Newham Hospital | Whipps Cross Hospital | Other sites | Grand Total |
|---|---|---|---|---|---|---|---|---|
| **A&E and urgent care activity** planned in 2010/11 | 31,400 | 42,000 | 1,800 | 400 | 3,600 | 800 | 0 | 80,000 |
| (percentage) | (39%) | (53%) | (2%) | (1%) | (5%) | (1%) | (0%) | (100%) |
| A&E and urgent care activity forecast in 2016/17 after the proposed reconfiguration | 23,500 | 55,200 | 2,000 | 500 | 5,300 | 2,100 | 0 | 88,600 |
| (percentage) | (27%) | (62%) | (2%) | (1%) | (6%) | (2%) | (0%) | (100%) |
| **Unplanned inpatient spells** planned in 2010/11 | 7,100 | 11,500 | 1,000 | 200 | 700 | 200 | 0 | 20,700 |
| (percentage) | (34%) | (56%) | (5%) | (1%) | (3%) | (1%) | (0%) | (100%) |
| Unplanned inpatient spells forecast in 2016/17 after the proposed reconfiguration | 500 | 17,800 | 1,100 | 200 | 2,800 | 500 | 100 | 23,000 |
| (percentage) | (2%) | (77%) | (5%) | (1%) | (12%) | (2%) | (0%) | (100%) |

N.B. All figures rounded to the nearest 100.

* These figures take into account demographic growth and other changes as well as reconfiguration proposals.

## Maternity and newborn care

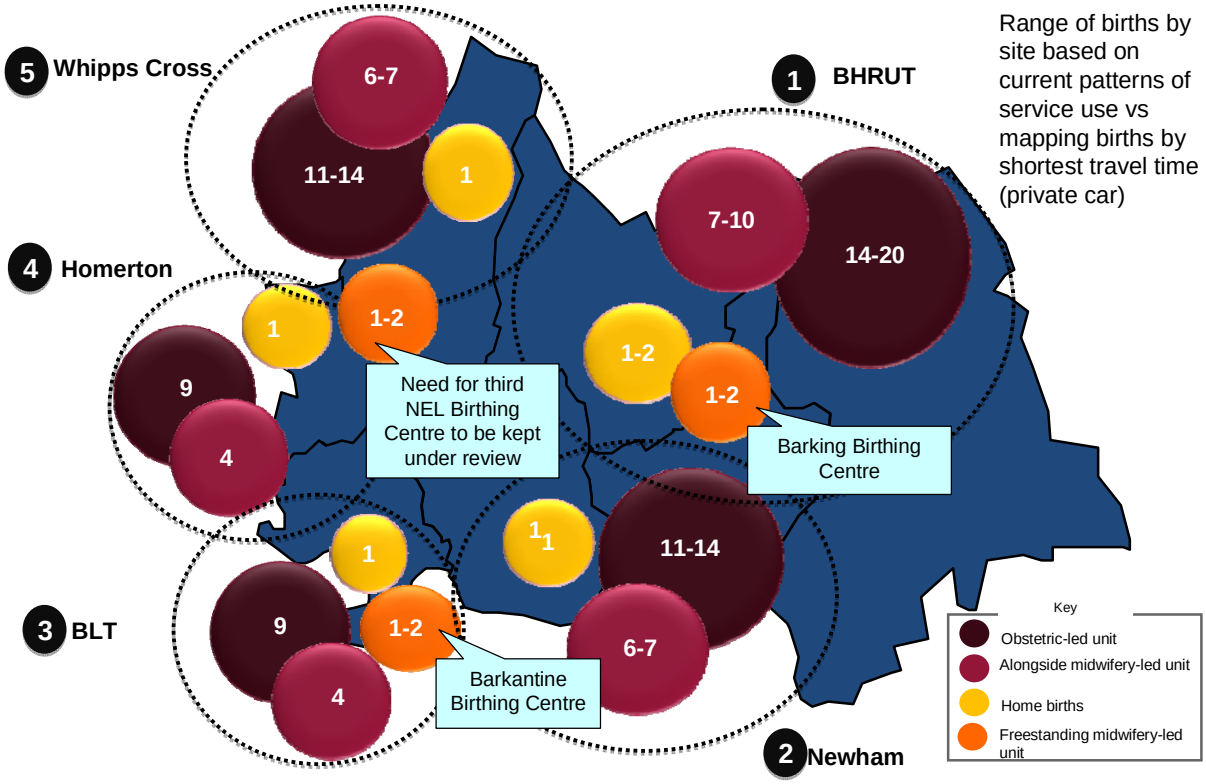
Each year around 2,400 women from Barking and Dagenham have their baby at Queen's, 800 give birth at King George and 100 at Newham. We know that clinical outcomes and patient experience for women in north east London are not as good as they need to be. In response to the feedback

received from people and organisations responding to the consultation the Clinical Working Group has set out a new model of care intended to deliver real improvements to maternity care services.

Our vision for women in Barking and Dagenham is to deliver a more 'normalised' care pathway for the majority of women who have straightforward pregnancies and births. We want to offer women with low risk pregnancies a real choice of birth setting, including home birth and midwifery-led birthing units – both 'freestanding' (community based such as at Barking Hospital) and 'alongside' (co-located with obstetric labour wards) as well as obstetric-led care at Queen's or Newham. Midwifery-led care is currently not available at Queen's and a new service provided there would mean that in future more women would be able to choose midwifery-led care than is currently the case. is currently the case.

King George Hospital would no longer provide maternity delivery services, but would continue to provide the full range of antenatal and postnatal care, including maternity day care / obstetric care.

## Five maternity campuses. Daily birth projections for 2016/17




## Scheduled (planned) care

The following table shows where **Barking and Dagenham** residents currently access planned care – and where we expect they will go in future if the reconfiguration proposals are taken forward. The

figures (rounded to the nearest 100) take into account demographic growth and other changes as well as reconfiguration proposals. These figures show the expected shift if King George becomes a centre of excellence for planned surgery. King George would also retain its cancer day care centre (Cedar Unit), develop its inpatient and day care rehabilitation services and establish a new local kidney dialysis service. *See section 2 of the main report.*

| **Hospital site →** / **Configuration ↓** | King George Hospital | Queen's Hospital | Barts & the London Hospitals | Homerton Hospitals | Newham Hospital | Whipps Cross Hospital | Other sites | Grand Total |
|---|---|---|---|---|---|---|---|---|
| **Scheduled inpatient spells** planned in 2010/11 | 4,300 | 6,800 | 1,200 | 100 | 300 | 500 | 0 | 13,200 |
| (percentage) | (33%) | (52%) | (9%) | (1%) | (2%) | (4%) | (0%) | (100%) |
| Scheduled inpatient spells forecast in 2016/17 after the proposed reconfiguration | 8,900 | 1,800 | 1,300 | 100 | 300 | 400 | 0 | 12,800 |
| (percentage) | (70%) | (14%) | (10%) | (1%) | (2%) | (3%) | (0%) | (100%) |

N.B. All figures rounded to the nearest 100.

* These figures take into account demographic growth and other changes as well as reconfiguration proposals.

## Children

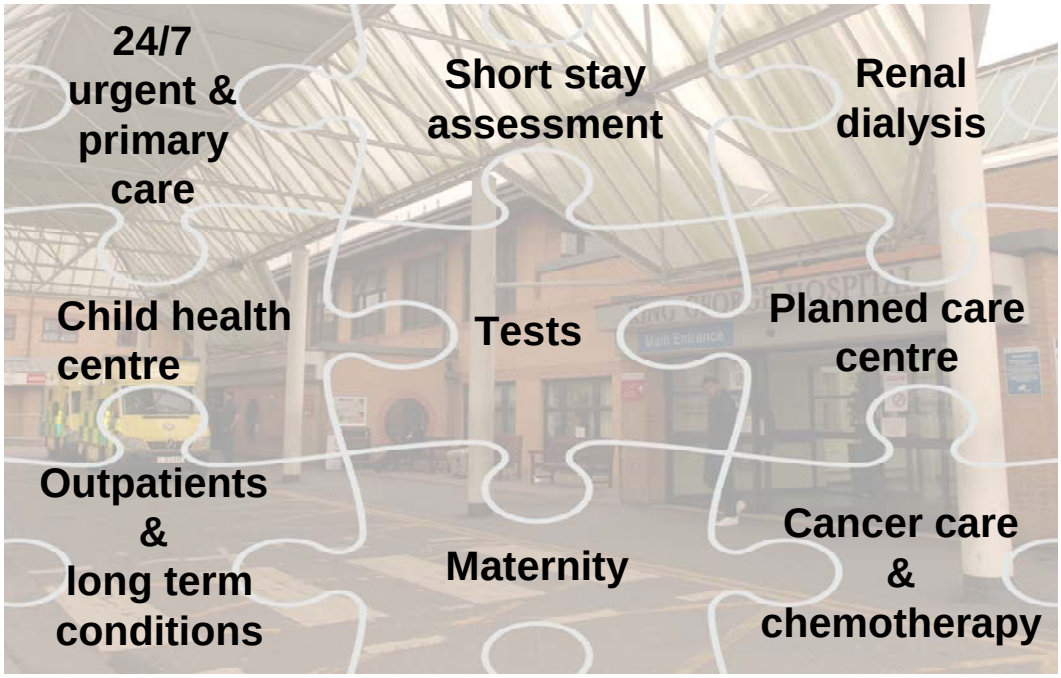
Most urgent care of children would be provided at pharmacies, GP surgeries, Barking Community Hospital and King George Hospital. The walk-in GP facilities, urgent care centre and children's assessment and treatment service at King George would be able to cope with a large range of children's illnesses and injuries. Newham and Queen's would retain their 24/7 paediatric services. The Royal London would continue in its current role as a specialist paediatric centre (particularly for children under six months). Queen's Hospital would also develop services for children with specialist surgical or high dependency medical care needs so that it is able to treat more children closer to their home.

Great Ormond Street Hospital will continue to provide specialist services to children who can't be cared for in north east London. *See section 2 of the main report.*

## The vision for King George Hospital

King George Hospital would continue to play an extremely important role in meeting the health needs of local residents as well as providing some specialist services for a wider population. We have described the proposals for urgent care, maternity and planned surgery facilities, and the services available to children. Seen as a whole, we believe King George would become a hospital that really met the health and well-being needs of the whole community. Long-term conditions

would be better managed, and services in the community would be more coordinated – meaning that more residents of the borough could avoid having to go to A&E or spend time in a hospital as an inpatient. *See section 3 of the main report.*




### Impact on other hospitals and other care

Under these proposals Barking and Dagenham residents would be able to access the services that they use and need most often at King George (e.g. urgent care, antenatal and postnatal care, children's services, rehabilitation and outpatient services). Barking Community Hospital will provide additional urgent care facilities and extra choice for mothers who want to have a midwifery-led birth but can currently only access this at Newham Hospital or by having a home birth.

The proposed changes will allow senior doctors to be available much earlier on in a patient's visit to the A&Es at Newham and Queen's, and consultants would be on hand 24/7 in labour wards – not just over half the time, as they are now. The obstetric unit at Queen's would not be as busy as more and more mothers choose to have their babies delivered in a midwifery-led unit and so safety would improve.

More specialist care would be improved at Queen's. *See sections 2 and 3 of the main report.*

### Travel

One theme that came up more regularly than any other in the consultation was concern over the time it would take to reach a hospital. We recognise this concern – and the difficulty that some people have in visiting hospitals – especially if they have no private means of transport. We are

working with Transport for London and have established a travel advisory group to look into how we can improve access to services in the area.

Under the proposed models of care overall access to care would improve. More care would be available closer to people's homes, either in their homes or in polyclinics, the Barking Community Hospital or in GP surgeries – which are now open for longer hours. For instance one proposal is to locate a new renal dialysis service at King George meaning that patients' regular trips would be shorter. Outpatient consultations and tests can be done in any of these settings, reducing the need to go to hospital. We also want to join up services in one-stop-shops so that patients need only make one visit rather than multiple visits to a range of different locations. In addition, because we intend to separate emergency surgery and planned operations fewer operations would be cancelled at the last minute – saving patients having to return at a later date and rearrange everything from time off work to child care and other domestic plans.

For some relatively rare or specialist care, for instance surgery on small children, when you really need the services of an A&E, or you're going to give birth, then for some residents the service will be further away. Clinicians have assured us that the extra travel time will be more than made up by the better, quicker, safer care that you would receive on arrival. *See section 4 of the main report.*

### Implementation

We understand that people have significant concerns about whether concentrating some activities will overload services. However the Clinical Working Groups, having reviewed all the evidence available, are clear that many services are already unable to cope. The proposed models of care would provide economies of scale (and therefore capacity to provide better and safer care) that are simply unachievable with the current arrangements. Better care also means that there needs to be fewer readmissions, less time spent in hospitals, less need for extensive rehabilitation – and so on.

We know the changes we have described will be challenging to deliver and we will only succeed by working together across all parts of the health and social care system to deliver the vision. We recognise the fundamental importance of a measured and sustainable approach to change. An implementation plan is being developed to ensure that changes are made describe what needs to be in place before changes could occur and what improvements would need to be made before any changes were made.

The new model of care would also require a different type of workforce, for instance clinicians working in hospital urgent care services that can provide the holistic care of a primary care clinician, possess acute medical skills and have the knowledge to be able to call upon or utilise the additional

specialist services available on a hospital site. We also believe that these changes would assist in recruiting and retaining staff in key areas.

In 2008 local GPs, clinicians and healthcare staff told us that there was a pressing case for radically changing the way we provide healthcare in north east London. That case has not gone away and is more pressing than two years ago.

## Questions and feedback

More information about the consultation and the proposals is available on Health for north east London's website, www.healthfornel.nhs.uk

If you have any further questions or feedback please contact the Health for north east London team – contact details are listed on the cover sheet of this report.

# Clinical recommendations following consultation

This report is intended as a guide to help stakeholders make comments to the clinical leaders before the inner and outer north east London Clinical Commissioning Boards and the Clinical Reference Group makes its final recommendations to the Joint Committee of PCTs. The full clinical reports can be found on the website www.healthfornel.nhs.uk or on request (address on front cover).



## 1. Background

Health for north east London is a clinically-led programme, led by all the PCTs in the area[1] in partnership with the local hospitals[2]. In December 2008 the seven PCTs in north east London met to discuss the challenges facing healthcare across north east London and to agree a way forward. In February 2009 the north east London *Case for Change* was published which set out the urgent need to make changes to local health services to ensure both their immediate and longer-term clinical viability.

[1] NHS Barking and Dagenham, NHS City and Hackney, NHS Havering, NHS Newham, NHS Redbridge, NHS Tower Hamlets, NHS Waltham Forest

[2] Barts and the London NHS Trust; Barking, Havering and Redbridge University Hospitals NHS Trust; Homerton University Hospital NHS Foundation Trust; Newham University NHS Trust; Whipps Cross University Hospital NHS Trust.

Between February and June 2009 the Clinical Reference Group (CRG) and Clinical Working Groups (CWGs) developed options for changes to hospital services focusing on those that would deliver the biggest improvements to clinical safety and patient care. The working group reports (including their membership) are available on our website www.healthfornel.nhs.uk or on request.

An options appraisal was undertaken against a set of clinical, workforce, capacity, access and deliverability criteria and then the options were assessed for their financial affordability. A set of proposals for change based on the outcome of this option appraisal process was agreed by the inner north east London (INEL) and outer north east London (ONEL) Joint Committees of PCTs (JCPCTs) on 24 November 2009.

The public consultation commenced on 30 November 2009 and closed on 22 March 2010 and the results of consultation were considered on 13 July 2010 at a joint meeting of INEL and ONEL JCPCTs. Full copies of all consultation outputs are available at;
www.healthfornel.nhs.uk/consultation/results-of-the-consultation

### 1.1 The 'four tests' and decision-making

Following publication of the White Paper, *Liberating the NHS*, the Department of Health published guidance on 29 July 2010 setting out four key tests for reconfiguration programmes. The guidance showed that in order to move ahead with the proposed changes the programme needs to demonstrate:

- support from GP commissioners;
- robust public and patient engagement;
- a clear clinical evidence base for the changes; and
- an understanding of the impact of the changes on patient choice (and demonstration that new service arrangements continue to offer choice to local residents as appropriate).

Since the consultation, the Clinical Working Groups and Clinical Reference Group have undertaken an extensive review of the original proposals since consultation. A summary of the recommendations from that review is set out in **section two** below. The full working draft reports are available from www.healthfornel.nhs.uk/resources/evidence-sources/clinical/ or on request and there are slide packs which are being used to present to local GPs and local authority members over the coming months.

We will present members of INEL and ONEL JCPCTs with a comprehensive summary of the outcome of these meetings so that they can take the views presented into full consideration as they make their decisions on any proposals. This decision-making meeting is scheduled for December

2010, however the JCPCTs will only make decisions if they are satisfied that the programme has met the four tests. Since we do not expect there to necessarily be a unanimous view from all stakeholders on the proposals the JCPCTs will need to weigh up the different views presented in coming to any decisions.

Strategic Health Authorities have been tasked with an external assurance role in relation to the four tests. As such, NHS London will undertake an external quality assurance process of the extent to which Health for north east London has met the new reconfiguration tests. The findings of this quality assurance process will be provided to the JCPCT to support decision-making.

# 2. Revised clinical recommendations

Since we reported the outcome of the consultation to the Joint JCPCT in July clinicians in north east London, including local GPs, have led a process to review the original proposals taking into account the feedback received during and after consultation[3].

Each of the four clinical working groups (Scheduled Care; Unscheduled Care; Maternity and Newborn Care; and Children and Young People's Care) has developed a report that describes the work done to address the issues raised over the last nine months and sets out their revised proposals to support decision-making. These reports are presented as 'working draft' documents (see above) and will be finalised over the next few weeks as further feedback is obtained on the proposals.

Below we provide a summary of how clinicians have revised the clinical proposals for change following consultation. The CWG recommendations on best practice and new models of care apply to all services and hospitals across north east London. However as before, the biggest changes relate to services to be provided by Barking, Havering and Redbridge NHS Trust at King George Hospital and the impact this has for Queen's Hospital and, to a lesser degree, Whipps Cross and Newham Hospitals. This report therefore focuses on these changes.

## 2.1 Unscheduled care (A&E, unplanned or emergency medical and surgical care including paediatrics and maternity services)

We consulted on reducing the number of hospitals in north east London that provide a full A&E, critical care[4] and maternity delivery facilities from six to five, with King George Hospital in

[3] Some of the clinicians had been involved in drawing up the proposals in order to provide continuity. However, to ensure proper objectivity and scrutiny new experts were also asked to join the groups.

Redbridge no longer providing these services. King George Hospital would remain an important local health resource providing enhanced primary care (e.g. GP services open throughout the day and out-of-office hours, tests, specialist advice), 24/7 urgent care services as well as a wide range of planned medical and surgical care services.

Whilst there was a degree of support for these proposals (particularly from NHS organisations and employees) these were the only proposals on which a greater proportion of respondents disagreed with the recommendations compared with those who agreed. Views were strongest in outer north east London where around half of those responding disagreed with the proposals. Respondents were concerned about the accessibility (and therefore timeliness) of services being further afield; about the capacity of services to cope with additional volumes; and about confusion over where to go.

Notwithstanding these concerns ***clinicians have endorsed the overall principle behind the original consultation proposals*** on the basis of the significant clinical benefits and better patient care that they believe can be delivered by concentrating care on fewer sites.

Workforce challenges, particularly in the care of children and in maternity (particularly doctor-led) services mean it is not possible to provide the appropriate level of senior clinical cover to safely support the full range of specialist services at all six hospitals. By reducing the number of hospitals providing these services it would be possible to provide more senior clinical presence on wards at Queen's, Whipps Cross and Newham hospitals so that seriously ill patients, or women who have complications in labour, could receive the best care as early as possible on arrival at hospital and throughout their stay.

### *2.1.1 Urgent care, A&E and inpatient care*

In the original case for change, clinicians made it clear that many A&E and urgent care services were under severe pressure. The reasons for this included:

- staff stretched too thinly across too many sites, making it more difficult to manage peaks and troughs in attendances;
- a lack of availability of specialist staff (sometimes driven by increasing sub-specialisation of clinical practice). This resulted in, for instance, children having to be cared for by clinicians experienced in adult assessment and treatment or the hospital having to call in specialists from elsewhere (on call or from other hospitals) or transfer the children to other hospitals;

[4] The term critical care was used to describe the range of medical and surgical specialist services required to support a full A&E and non-elective inpatient service.

- A&Es full of patients requiring urgent care but not emergency or complex care – and often requiring a much more holistic treatment, for instance by a GP; and
- too many patients being admitted to hospitals because there were no alternative treatment options.

***Local clinicians have reviewed the original proposals and considered the consultation responses. They endorsed the recommendation to reduce the number of hospitals in north east London providing traditional A&E and acute medical surgical and paediatric care from six to five. King George Hospital would provide extended primary care and 24/7 urgent care services.***

In response to the concerns raised, however, our clinical advisors are recommending that the NHS invests in significantly developing urgent care services – training clinicians in the required new roles, describing new pathways of care that integrate emergency, urgent and primary care and developing new standards and protocols. This would enable A&E services to really focus on those patients with the most serious conditions.

Clinicians have reviewed the case mix at King George A&E and urgent care centre where more than 75% of patients are discharged home without needing admission.

- Only around 20% of patients require admission. If a GP or ambulance crew felt it was likely that a patient would require admission (and most of these patients arrive via these referral routes) they would arrange for patients to be taken straight to a neighbouring A&E.
- Most local residents would continue to receive their initial urgent care at King George Hospital. Approximately 50% of patients who attend the hospital could have their needs met by a primary care service.
- For many of the remaining 30% of patients who don't need full A&E or inpatient services (and for some of the patients who are currently admitted for very short stays) but aren't suitable for the current urgent care service, clinicians have recommended that we develop ***short stay assessment and treatment services for adults and children at King George Hospital*** so that we can provide a really good local alternative to A&E and inpatient care.

The ***short stay assessment and treatment unit*** would be staffed by a team of skilled clinicians with expertise in primary care assessment, diagnosis and treatments as well as expertise in emergency medicine. The service would take responsibility for ensuring that all patients presenting at King George are assessed and directed to the most appropriate service for their care, including ensuring the safe and effective transfer of patients needing A&E care to an A&E hospital. When necessary they would be responsible for stabilising acutely unwell patients prior to transfer.

The new short stay assessment service would offer a tailor-made service for patients who would benefit from longer periods of observation, assessment and treatment including access to a range of diagnostic tests not currently available to primary care clinicians. The service would have good access to specialist advice from hospital clinicians (including for example paediatricians, geriatricians, mental health specialists) to support effective clinical decision-making. The service would work closely with community health and social care services, including mental health services, so that as many patients as possible could be cared for in the community without recourse to a hospital admission.

Local urgent care services have reported that they are experiencing difficulty in recruiting sufficient skilled senior clinicians to staff current urgent care models. Whilst people or teams with the right range of skills may not be readily available now we believe that with a clear workforce strategy we can develop our workforce to successfully deliver this model.

We know that patients often experience difficulty accessing urgent care and are not always certain about which service is most appropriate to their needs. We know as well that current services don't always work as well they should and that sometimes people get sent round in circles looking for care (no appointment available at their GP practice, local urgent care or walk-in centre can't meet their needs and sends them to A&E, A&E directs them back to their GP). Many GP practices are extending their opening hours and working together to improve out-of-hours GP cover and we will continue to focus on improving access to primary care as a priority. We are also absolutely committed to developing a service at King George that genuinely meets the needs of the majority of patients with urgent and emergency care needs. This would ensure that those patients that do need to be transferred to an A&E or to an inpatient bed are managed safely and effectively but also that other patients, even where their needs are quite complex, could have their needs met locally and are not passed round and round the system.

We understand that as well as making services simpler to use we also need to do more to explain to local residents how and when they should access urgent care and this would be a priority if changes to services were introduced.

We believe if we strengthen urgent care services in line with the recommendations in the unscheduled care working group report then we can significantly improve services for patients and reduce pressure on hospital services. We will not make changes to A&E services at King George Hospital until we are confident that new services are in place to make sure changes can be made safely.

**Further details of proposed improvements to urgent and emergency care services can be found in the unscheduled care CWG report** www.healthfornel.nhs.uk/resources/evidence-sources/clinical/

For further information about the capacity of neighbouring hospitals to manage the acutely unwell patients that would previously have been treated at King George Hospital see section three below.

### *2.1.2 Maternity and newborn care*

Previous studies have shown that better supervision of junior staff, and the presence of a more experienced doctor at the time of a complication in pregnancy, could have prevented more than three-quarters of all serious problems in childbirth[5] and that better management would make a difference in 35% of all stillbirths and deaths in infancy[6].

We also know clinical outcomes and patient experience for women in north east London are not as good as they need to be and the Maternity and Newborn Clinical Working Group (CWG) has set out a new model of care intended to deliver real improvements to local maternity care services. The CWG has carefully considered all the feedback received in consultation and in response has significantly enhanced the vision for maternity services in north east London.

In common with A&E, acute medicine and surgery, ***local clinicians who reviewed the original proposals and consultation responses endorsed the recommendation to reduce the number of hospitals in north east London providing maternity birthing services from six to five***. King George Hospital would no longer provide maternity delivery services, although it would continue to provide the full range of antenatal and postnatal care, including maternity day care.

Concentrating doctor-led deliveries onto five sites would help these hospitals provide 24/7 consultant presence on labour wards. Currently no hospital is able to provide this level of care and consultant obstetricians are usually only available on labour wards for just over half of each 24 hour day. Women who experience complications in their labour 'out of hours' have their care managed by a doctor in training or they have to wait for the on call obstetrician to be called in.

In looking at the responses, the CWG:

- noted the vision of respondents wanting to see a more 'normalised' care pathway for the majority of women who have straightforward pregnancies and births and who would be

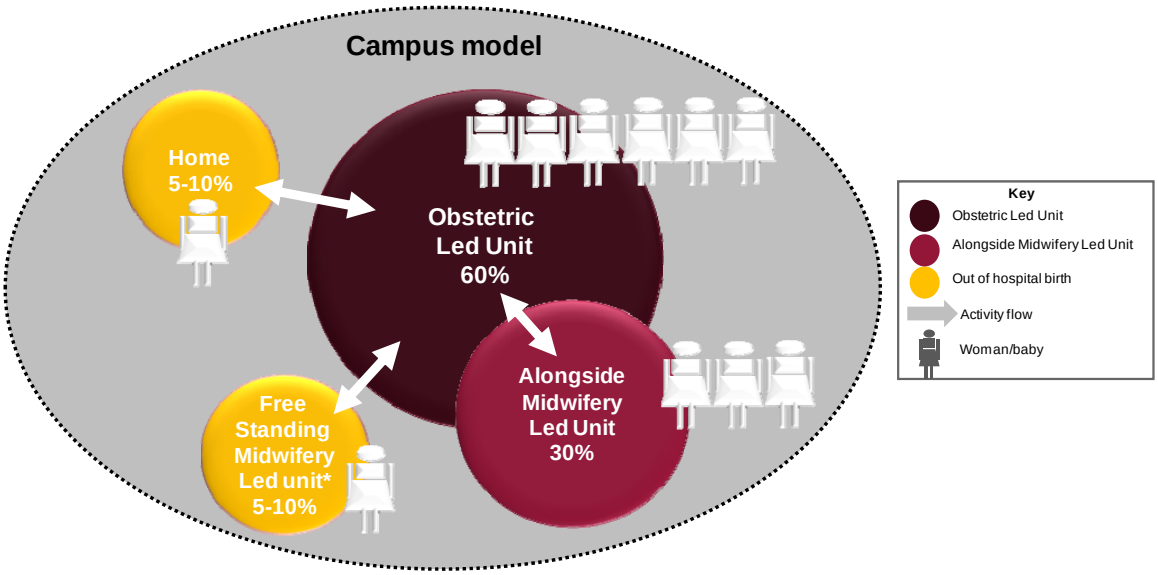
[5] The Future Role of the Consultant, Royal College of Obstetrics and Gynaecology, Dec 2005

[6] Summary of findings from the root cause analysis of 37 adverse events and near misses in obstetrics: A report for the NPSA, 2000

suitable for midwifery-led care. The CWG was clear that women with low risk pregnancies should be offered a real choice of birth setting, including home birth and midwifery-led birthing units – both 'free-standing' (i.e. based in the community) and 'alongside' (i.e. located next to an obstetric labour ward in a hospital);

- considered the concerns raised around the potentially large size of maternity units – at Queen's Hospital in particular; and
- acknowledged the clear preference stated by women to deliver in midwifery-led units 'alongside' hospital doctor-led units.

In response, the CWG has proposed a 'maternity campus model' where all campuses would offer access to the full range of birth settings (see diagram below). Queen's Hospital would develop a new 'alongside' midwifery-led service with capacity to manage more than 3,000 births per year (7-10 babies per day). These proposals would not therefore require the current obstetric unit at Queen's Hospital to manage more births. In fact we would expect to see a small reduction in the number of births being managed through the current Queen's obstetric unit.

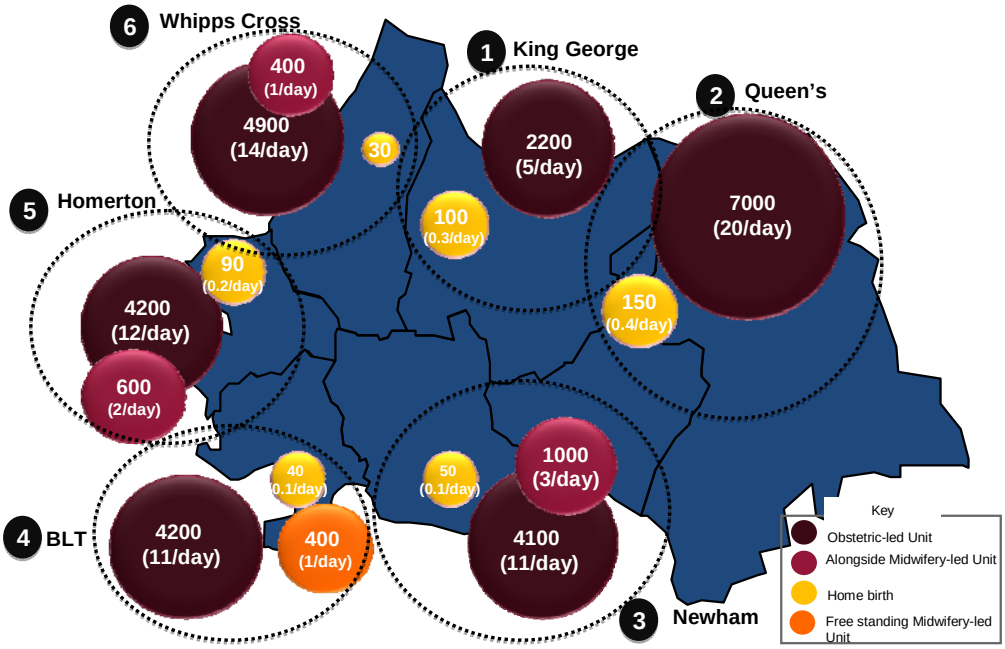



In addition we have also reviewed our initial demand / capacity modelling and identified that as many as 30% of women currently having their babies at either Queen's or King George Hospital actually live closer to an alternative local hospital (Whipps Cross or Newham). We think that many women who would normally give birth at Queen's or King George Hospital may be happy under the proposed future model to access care from one of these nearer hospitals.

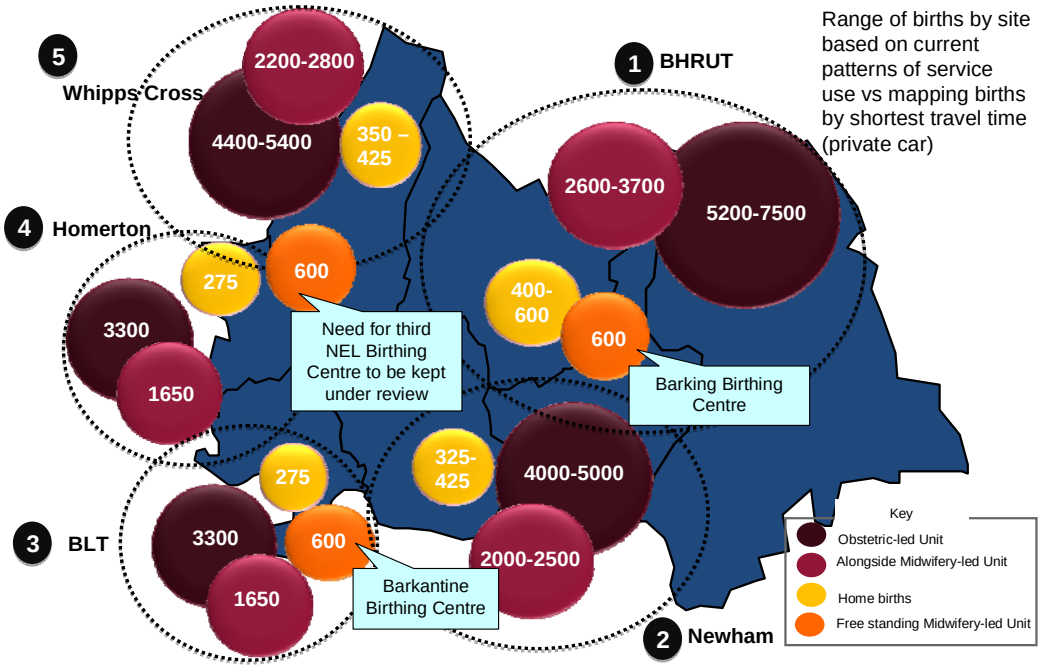
We have commissioned a small study to help us to better understand the factors that influence women's choice in relation to maternity delivery services. This work will report in mid-November and

will be available to support local clinicians and the JCPCT in their final decision-making. Both Newham Hospital and Whipps Cross Hospital have indicated that they would be willing and able to expand maternity capacity to take on some of the work currently undertaken by BHRUT if this is required.

## Current model. Six maternity sites – annual birth projections




## Five maternity campuses – annual birth projections for 2016/17




Range of births by site based on current patterns of service use vs mapping births by shortest travel time (private car)

The CWG also considered whether it would be possible to retain a midwifery-led unit at King George Hospital as well as the new free-standing midwifery-led unit due to open at Barking Hospital in 2011. The Barking Birthing Centre will provide state-of-the-art midwifery-led care facilities similar to those provided at the Barkantine Polyclinic in Tower Hamlets.

As part of the transition to the proposed new model of care at Queen's Hospital it is likely there would be a period where King George operates as a free-standing midwifery-led unit. Upon ongoing evaluation of the demand for this level of care at King George, a decision would be taken about the long term viability of retaining the 'transitional' free-standing midwifery-led unit at King George Hospital, especially taking into account factors such as its geographic proximity to Barking.

We recognise the significant workforce challenge that faces us in relation to recruiting and retaining sufficient skilled midwives and obstetricians to manage the growing number of births in north east London each year and to deliver the clinical vision that we have set out. However clinicians have told us that achievement of their 'vision' for maternity services will help recruit and retain midwives and encourage some to return to work. We are currently developing a workforce strategy designed to help us meet this challenge.

**Further details of our vision for maternity and newborn services in north east London can be found in the CWG report** www.healthfornel.nhs.uk/resources/evidence-sources/clinical/

### 2.2 Scheduled (planned) care

In the original proposals the clinical working groups recommended that all trusts in north east London adopt best practice guidance regarding separating planned surgery from unplanned and emergency surgery – either on the same site or on a separate site. We also specifically recommended that Barking Havering and Redbridge University Trusts (BHRUT) should move 'uncomplicated' planned surgery from Queen's Hospital to King George Hospital.

Separating elective care from emergency pressures through the use of dedicated beds, theatres and staff can (if well planned, resourced and managed) reduce cancellations, achieve a more predictable workflow (and therefore save money), provide excellent training opportunities, increase senior supervision of complex/emergency cases, and therefore improve the quality of care delivered to patients[7].

[7] Separating emergency and elective surgical care: Recommendations for practice, Royal College of Surgeons of England, 2007

The proposals were broadly supported within the consultation (56% agreed to the principle of separating emergency and planned surgery) with 18% against; and 43% agreed to the recommendation to move planned surgery from Queen's to King George with 20% against). **The Scheduled Care Clinical Working Group endorsed the proposals** and has undertaken further work to describe in more detail which surgery is generally suitable (and which is not) for a 'planned surgery centre' such as the one proposed for King George. BHRUT clinicians have worked with these proposals to develop specific recommendations relevant for King George Hospital and Queen's.

**Further details of our vision for scheduled care services in north east London can be found in the CWG report** www.healthfornel.nhs.uk/resources/evidence-sources/clinical/

### 2.3 Children and young people

***The Children's and Young People Clinical Working Group has broadly endorsed the proposed model of care for children in north east London requiring hospital care.*** This would build on The Royal London's current role as a specialist paediatric centre and see Queen's Hospital further develop its services for children, so that more children could be cared for nearer their home.

Whipps Cross, Homerton and Newham would retain 24/7 paediatric services but would transfer children with specialist surgical or high dependency medical care needs to The Royal London.

Great Ormond Street Hospital will continue to provide specialist services to children who can't be cared for in north east London.

#### *2.3.1 We recommended that all hospitals with A&E departments should have separate facilities for children and provide 24/7 paediatric care.*

**This recommendation was supported in the consultation and endorsed by the Children and Young People's Clinical Working Group** reviewing the proposals. The clinical group has done some further work to describe how children's services in A&E hospital settings should be organised.

The key principle that clinicians have identified is the importance of senior clinical decision-making as early in the pathway as possible. Decisions about the best care for a child should be based on an individualised assessment of each child's need. Wherever possible care should be provided out-of-hospital and services should be organised in such a way as to support this. Where inpatient care is required this decision should be made by a senior doctor and children in hospital should have their care reviewed regularly by a senior children's doctor (paediatrician).

### *2.3.2 We recommended that children requiring hospital care of more than two days should be transferred to more specialist children's services at The Royal London and Queen's Hospitals.*

Having reviewed the evidence and consultation responses **the Clinical Working Group endorsed the development of more specialist services at The Royal London and Queen's Hospital** and agreed that children with high dependency or specialist needs should be cared for at these hospitals. However the group noted the comments made by parents concerned about their children being treated some distance from home and have suggested that decisions about when to transfer should be based on an individual assessment of the child. The group considered that expected length of stay is not a good predictor of which children would benefit from this more specialist level of care. Further work to provide guidance for local clinicians about when to transfer a child is being developed. This will ensure that more children are treated locally than originally anticipated but still have access to more specialist care when necessary.

### *2.3.3 We recommended that all surgery on children in north east London under two years of age should only be performed at The Royal London and that all urgent surgery and all complex surgery on children between the ages of two and 15 should only be performed at The Royal London and Queen's.*

**Clinicians have endorsed the principle that The Royal London and Queen's should act as a specialist resource for paediatric surgery.** However the CWG has developed more detailed guidance to support decision-making about which children should transfer for specialist care and the procedures and conditions necessary for surgery to be safely undertaken on local sites. This will result in more surgery being retained locally than originally anticipated. However all services will need to demonstrate that they can meet an agreed[8] set of minimum standards (skills and experience of staff, safeguarding children, child and family appropriate facilities).

Nevertheless The Royal London will continue to be the major provider of surgery on children aged two and under in north east London and Queen's will further enhance its paediatric surgery services such that as many children as possible are able to be treated locally.

### *2.3.4 Children's services at King George Hospital*

The proposals for King George Hospital recommended that A&E and inpatient care for children would no longer be provided at the hospital and children requiring this type of care would need to be taken directly (or transferred) to Queen's, Whipps Cross or Newham – these recommendations are discussed earlier in this section.

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[8] Draft standards included within CWG report. Further work required to finalise an agreed set for NEL.

Notwithstanding this, the clinical working group has reviewed the proposal to provide a range of other services at King George Hospital to offer care for the majority of children requiring urgent assessment and treatment. **The group considered the evidence and results of the consultation (49% of respondents supported the proposal with 9% against) and have endorsed the recommendation** which would see the following services at King George:

- a 24/7 urgent care service and a short stay assessment and treatment unit (described above). Whilst these services would be for adults and children, each would have a dedicated children's area and would be supported by same day / next day paediatric outpatient clinics with rapid access to specialist advice;
- a child health centre providing specialist child health services (neuro-disability, therapy services) and Child and Adolescent Mental Health Services (CAMHS). These services are currently located in very poor quality buildings that provide a poor patient experience and prevent the services developing. We believe bringing these services together on the King George site would offer significant opportunities to improve the care of vulnerable children and improve co-ordination of care across organisations. We need to do more work with our partners to develop plans for this service; and
- safeguarding services including child protection medicals.

## 3. The vision for King George Hospital

King George Hospital would continue to play an extremely important role in meeting the health needs of local residents as well as providing some specialist services for a wider population.

| **Service** | **Description / explanation** |
|---|---|
| 24/7 urgent care and GP services | Open 24/7,with 12 hour a day walk-in GP practice, booked appointments, better access to tests, GP out-of-hours service and telephone advice.<br>Access to range of specifically targeted diagnostics and urgent care support service. |
| Short stay assessment and treatment services for adults and children. | For the observation, assessment and treatment of those patients who do not require a hospital inpatient admission. Would have access to a wide range of specialist advice. |
| Diagnostics | Expected to include ECG, pulse oximetry, spirometry, x-ray, ultrasound, vascular doppler, colonoscopy, and standard haematology, microbiology and pathology. |
| Antenatal and postnatal maternity day care | Midwifery-led antenatal and postnatal care including obstetric review, ultrasound & foetal heart-rate monitoring. |

| | |
|---|---|
| Child health centre | Would focus on providing non-acute children's services, enabling co-location of several inter-linked service areas and specialist practitioners. This would support child well-being, prevent A&E hospital attendances and inpatient admissions, and support families to provide care for their child at home. Services could include:<br>• Specialist children's nursing support to the urgent care service<br>• Children's outpatient clinics including ongoing management of long term conditions<br>• Child and Adolescent Mental Health Services (CAMHS), relocated from Loxford (for Redbridge)<br>• Child protection and safeguarding services including child protection medical assessments (for Redbridge)<br>• Multidisciplinary services such as children's neuro-developmental assessments could also be relocated to King George from an existing base at the Kenwood Child Development centre (for Redbridge)<br>The centre would have close links to care outside hospital services such a paediatric homecare teams. |
| Outpatient facilities including long-term condition management | Wide range of outpatient and diagnostic services including same day /next day appointments where rapid access to specialist advice is required to support primary & community based care.<br>One-stop-shop, multi-disciplinary approach, with focus on long term condition management. |
| Cancer day care (Cedar Unit) | The Cedar Unit will continue to provide chemotherapy, supportive treatments such as blood transfusions and patient advice to over 400 cancer patients each year. |
| Renal dialysis | 24 renal haemodialysis stations to provide a local service and meet the growing need for this service in outer north east London. |
| Inpatient and day care rehabilitation services | Multidisciplinary rehabilitation and intermediate care services, provided on an outpatient basis.<br>Rehabilitation and intermediate care beds (approximately 50 beds), relocated from Heronwood and Galleon in Wanstead.<br>Stroke rehabilitation service, with specialist unit including inpatient beds, and relocation of twelve stroke rehabilitation beds from Grays Court in Barking and Dagenham. |
| Planned surgical centre | A significant proportion of planned surgery would be relocated from Queen's to King George hospital.<br>Services would include:<br>• Day care and inpatient care, outpatient clinics and pre-op assessments |

| | |
|---|---|
| | • Wide range of specialities and procedures including e.g. orthopaedics (hips and knees) eye surgery, treatment of hernias, breast surgery<br>• Surgical high dependency unit<br>• Planned medical care including endoscopy. |

### 3.1 How would these changes impact on neighbouring hospitals?

Before consulting on the proposals for King George Hospital we modelled in detail the implications of the changes on activity, capacity and finances. This work was set out in the pre-consultation business case which can be found on our website http://www.healthfornel.nhs.uk/consultation/joint-jcpct-meetings/jjcpct-meeting-24-november-2009/

We are in the process of updating all of this work to take account of the most up-to-date activity information. The latest projections for population growth are used but the model also builds in a range of forecasts about growth in demand for hospital services (for instance looking at changes to the way we expect people to use hospital services) and changes to health technology. For example:

- 50% of current A&E and urgent care centre attendances to be managed through urgent care services in future (currently 30 – 40%);
- small reduction in unplanned medical admission due to better access to specialist advice and better management of long term conditions in community and primary care settings; and
- more outpatient care in community and primary care settings (reducing hospital-based outpatient care).

We have also modelled where we think patients (and therefore activity) will flow should changes to services proposed for King George Hospital go ahead. This modelling is based on current patterns of service use and travel time analysis. The new urgent care and short stay assessment services at King George will manage up to 65% of current patients. However where full A&E or emergency medical and surgical inpatient care is needed this will be provided at a neighbouring hospital. Our modelling suggests that Queen's Hospital will receive the highest amount of additional activity with relatively smaller flows to Whipps Cross and Newham hospitals.

The key issue from a capacity planning perspective is acute medical and surgical bed capacity. Required bed numbers are calculated based on number of admissions x average length of stay (this analysis is done at a detailed level that describes the types of admissions by hospital and takes account of age and complexity of case mix).

Current lengths of hospital stay in north east London are much longer than average – with significant differences between local hospitals. This is not good for patients and is a key factor in the financial difficulties that some of our hospital trusts are facing. Reducing length of stay is therefore both a clinical and a financial priority for local hospitals and will help ensure that we have sufficient bed capacity on each site to meet the needs of the new model of care. Our modelling shows that by reducing length of stay in line with London and national averages both Whipps Cross and Newham can manage the additional patient numbers that would flow to them under the proposals – without any additional beds. However to deliver the new model of care there is a requirement for a small increase in medical and surgical inpatient beds at Queen's Hospital, once length of stay efficiencies have been achieved.

We are already making good progress in many areas. For example a new A&E rapid response team at Queen's Hospital is preventing between five and ten hospital admissions per day and Whipps Cross Hospital recorded a 36% reduction in children attending its A&E when it introduced an urgent care centre in 2006.

We are working with local hospitals to ensure that we have robust plans in place to create the required capacity at each site and with the London Ambulance Service to ensure ambulance staff are experts in assessing whether patients need to be treated at an A&E of if they could be better cared for at the scene, or in an urgent care centre.

# 4. Addressing key themes and concerns arising from consultation

## 4.1 Travel and access

During consultation we heard people's concerns about travel. Respondents described current problems for patients and visitors in accessing hospitals and specific concerns about their journeys becoming more difficult, expensive and time-consuming as a result of the proposed changes – in particular the changes to A&E and maternity services at King George Hospital. We believe the revised clinical recommendations set out above are the best balance between addressing the urgent quality and sustainability issues identified by local clinicians in local services and ensuring a good level of access to care.

We recognise the concerns about travel and access to health services and are committed to working with local stakeholders (including Transport for London (TfL), local authorities and interested local groups) to agree a clear, deliverable set of priorities to address the issues raised. A key priority is working with TfL to ensure relevant bus services drop-off and pick-up from Queen's

and King George hospitals. Other priorities include ensuring patients and visitors are well informed about their travel options and developing a consistent approach to car parking charges across hospital sites. These issues will be taken forward through the **Travel Advisory Group** – for more information visit www.healthfornel.nhs.uk/events/engagement-events-in-september-2010/travel-advisory-group-discussion-event/

In our original pre-consultation business case we set out a commitment to improve overall access to services. This could be by:

- providing care closer to home or in people's homes;
- delivering services usually provided in a hospital, in the community – for instance in polyclinics; and
- joining up services in one-stop-shops so that patients need only make one visit rather than multiple visits to a range of different locations.

In developing our clinical recommendations we have given careful thought to assessing which parts of the care pathway could and should be provided out-of-hospital in locations closer to home. In maternity this means providing a much wider range of ante and postnatal care in community-based settings. Equally we are committed to providing as many services as possible at King George when these can be provided safely and effectively. Our plan for a new short stay assessment and treatment service is an example of this; as is the proposal to develop renal dialysis provision locally. A further example is our plan to increase the range and availability of paediatric outpatient services at King George Hospital (currently mainly provided at Queen's). So, although the profile of services at King George Hospital would change, access to a whole range of services currently not provided locally would improve.

See the Health for north east London website for more detailed analysis of the impact of our proposals on travel times for local residents www.healthfornel.nhs.uk

### 4.2 Capacity and quality

As can be seen in the revised clinical recommendations set out above, local hospital services face a range of pressing quality and sustainability issues in their current configuration. Local hospitals are not meeting best practice for maternity and paediatrics because staff and resources are spread too thinly. A&E services find it difficult to provide the best service to those requiring specialist care as well as dealing with more minor conditions.

At their core, the revised recommendations aim to ensure local people get the high quality services they are entitled to, and ensure those services continue to improve and develop in the future. Only

by concentrating some of the clinical expertise and working in new ways can we hope to provide the best level of care.

We understand that people have significant concerns about how concentrating activity – in particular obstetric-led maternity services, A&E and acute medical services – can possibly work. We have been asked how Queen's hospital will manage, given that services there already seem unable to cope with current activity.

Sending more activity to a struggling service does not, on the face of it, seem to be the right answer. However, this is not about managing more people to the same services. In many circumstances the proposals suggest building extra capacity where it is most needed – for instance in alongside midwifery-led maternity units or utilising the economies of scale that would accrue from putting services together. However, as can be seen in the clinical recommendations, this is about fundamentally changing how maternity, emergency and urgent care services function at Queen's and across north east London. By changing how clinical teams work together and how they work with colleagues in primary, community and social care we can provide better, safer services able to manage patients more effectively in hospital and ensure they return home quicker, avoiding the problems associated with delayed discharge and lengthy hospital stays.

Whether the clinical recommendations set out above are implemented or not, hospitals and commissioners are already addressing the high average lengths of stay and high demand, in particular around acute admissions, that are symptoms of current healthcare in north east London. These issues represent real challenges to good patient care and effective use of resources. Patients who stay in hospital longer than they clinically need to (perhaps because of a lack of senior clinical input or ineffective discharge systems or poor hospital processes) are vulnerable to infection. Older people, in particular, lose confidence and their ability to return to independent living is diminished. Many acute admissions can be avoided by better long term condition management and improved care pathways for frail older people. The recommendations to provide more holistic care in hospital urgent care centres across north east London (and the proposed services at King George in particular) aim to tackle this problem.

### 4.3 Workforce

Concerns were expressed in the consultation about the impact of the proposed changes on the workforce, in particular around recruiting and retaining staff and ensuring the workforce is trained and developed to be able to work effectively in any new clinical models of care.

However, as shown above, there are already severe workforce challenges that threaten the sustainability of local services, in particular in specialist paediatric care, A&E and maternity services. These proposals aim to address the significant workforce gaps which mean that, however good our staff are, and however hard they work, we are failing and will continue to fail to offer patients a consistently high level of care.

We believe the clinical models set out above, that have been devised by local clinicians, will support us in developing, recruiting and retaining the right local workforce so that we can better meet the needs of local people. However we recognise the need to develop clear workforce strategies to support us in delivering the proposed new models of care and we will be prioritising this work over the coming months.

### 4.4 Implementation

Many people responded to the consultation by agreeing with the principles and recommendations but questioning whether the NHS had the ability to implement the changes and make them work well.

We know the changes we have described will be challenging to deliver and we will only succeed by working together across all parts of the health and social care system to deliver the vision. We also recognise the fundamental importance of a measured and sustainable approach to change. Clearly the full benefits of the recommendations will only be achieved with careful and effective implementation. An implementation plan is being developed to describe:

- what needs to be in place before changes could occur;
- what improvements would need to be made before any changes were made; and
- information needed to support capital (generally building) plans or workforce development.

For instance we believe in order to transfer the obstetric-led maternity delivery service at King George Hospital we 'must have':

| **King George Hospital maternity 'must haves'** |
|---|
| A clear workforce strategy to ensure we can recruit and retain sufficient staff to manage the increasing birth rate |
| Demonstrable progress in increasing the percentage of births in midwifery-led settings |
| Local protocols in place to support safe care in midwifery-led settings |
| Queen's Hospital alongside midwifery-led unit open and operating effectively |
| Quality assurance processes and service improvement plans for all maternity campuses |
| **The earliest likely timeframe for changes to maternity services is early 2012** |

And in order to transfer the A&E, acute medicine and surgery service from King George Hospital we believe we 'must have':

| King George Hospital A&E, acute medicine and surgery 'must haves' |
|---|
| A workforce strategy |
| Demonstrable progress in providing improved primary care both in hospital (the GP facility is currently due to be in operation in April 2011) and in the community; and in reducing admissions to hospital – e.g. from nursing homes, for end of life care and through better management of long term conditions |
| Urgent care services on hospital sites managing a minimum of 50% current urgent and emergency attendances |
| A new short stay assessment and treatment unit at King George Hospital open and demonstrably delivering safe and effective care such that 65% of current urgent and emergency attends on King George Hospital site are being managed without recourse to A&E or inpatient admission |
| Demonstrable progress in reducing length of stay / clear demonstration of available capacity on receiving sites. Reduction in 'delayed transfers of care' |
| Improved access to tests and improved turnaround times for test results, to support primary care management of acute medical conditions – standards to be defined |
| Barking, Havering and Redbridge University Hospitals NHS Trust's (BHRUT) Care Quality Commission registration conditions in relation to safeguarding children removed. |
| **The earliest likely timeframe for changes to (adult) A&E and acute medical and surgical changes is April 2013 (changes to paediatric services may be required sooner than this on sustainability grounds)** |

We would welcome your views on this list and your suggestions for any additional 'must haves'.

**We will only make changes to services when we are absolutely confident we are in a position to do so safely.**

## 5. What happens next?

This document has been developed to support engagement with local stakeholders during October and November, prior to a Joint meeting of the ONEL and INEL Joint Committees of PCTs planned for December 2010. This phase of engagement will particularly focus on ensuring we fully understand the views of GP commissioners and GP practices locally as well as providing a formal opportunity for our local authority partners to comment on our revised proposals for change. Meetings have also been scheduled with inner and outer north east London Joint Overview and Scrutiny Committees.

The programme's People's Platform and all the Local Involvement Networks (LINKs) will also be invited to comment on the revised proposals. Patients and members of the public will be able to

feed in their comments through the Overview and Scrutiny Committees, LINks or directly via email, letter or the website.

GP commissioning leads in each PCT are holding meetings with local GP practices to ensure that they fully understand the level of support in primary care. GP commissioning leads will be asked to provide an assessment of the level of GP support for the proposals to assist the Joint Committees of PCTs in their decision-making.

**Key meetings:**

| | |
|---|---|
| Health for north east London Clinical Reference Group | 17 November |
| INEL Transition GP Commissioning Board | 19 November |
| ONEL Clinical Commissioning Advisory Board | 30 November |
| Joint meeting of the inner and outer north east London JCPCTs | 15 December |